Model Agreement for **Collaborative Drug Therapy Management** (CDTM) for **Community Pharmacy** Practice Settings

(A sample agreement provided by the Massachusetts Board of Registration in Pharmacy)

Part I. Parties to the CDTM Agreement

A. Authorized Pharmacist

Name:

License No.

Practice Location:

Email Address:

Work Telephone:

Home Telephone:

Mobile Telephone:

Fax Number:

Emergency Contact Info:

B. Supervising Physician

Name:

License No.

Practice Location:

Email Address:

Work Telephone:

Home Telephone:

Mobile Telephone:

Fax Number:

Emergency Contact Info:

Part II. Scope of CDTM Practice – Disease States, Prescriptive Practice Authority, Guidelines and Protocols

A. List the disease state(s), and detail scope of practice, being co-managed under the CDTM Agreement

Disease State	Scope of Practice	Applicable Prescriptive Practice Guidelines and Protocols (attach or reference)
Asthma **Diagnosis:** Primary □ Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	
Chronic Obstructive Pulmonary Disease **Diagnosis:** Primary □ Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	
Diabetes **Diagnosis:** Primary □ Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	
Hypertension **Diagnosis:** Primary □ Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	
Hyperlipidemia **Diagnosis:** Primary □ Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	
Congestive Heart Failure **Diagnosis:** Primary □ Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	
HIV or AIDS **Diagnosis:** Primary □ Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	
Osteoporosis **Diagnosis:** Primary □ Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	

Other (specify)_____ **Diagnosis:** Co-morbid □	□ Initiate, modify or discontinue medications □ Order and evaluate laboratory tests □ Obtain and check vital signs □ Collect and review patient histories □ Other: _____	

B. Communication and Supervision Protocols

Describe, with specificity, how communication and supervision between the authorized pharmacist and supervising physician will be accomplished, including the frequency of communication and arrangements for exchanging information about test results, copies of prescriptions, other patient information, for the identification and transmission of urgent information, and for back-up coverage when the supervising physician or authorized pharmacist is not accessible (e.g. during vacation or illness).

C. Pharmacist Prescribing Authority and Outcome Measurements

Describe, with specificity, pharmacist prescribing authority and outcome measurements pursuant to the CDTM Agreement.

D. Responsibilities of Parties and Protocols regarding Patient Records, Risk Management Activities and Administration, and any authorized delegation of CDTM Services

Responsibility	**Protocol(s)**	**Responsible Party(ies)**
Record Creation		
Record Maintenance		
Record Storage		
Record Retrieval		

Record Confidentiality		
Record of Patient Referral and Informed Consent		
Risk Management Activities		
Description of any Delegation of CDTM Services allowed under the Agreement 247 CMR 16.04(2)		
Additional CDTM Agreement responsibilities as applicable		

Part III. Attestation of Authorized Pharmacist regarding Qualification to Enter into this CDTM Agreement

I,

_____

Print Name and MA License # of Authorized Pharmacist

hold a current unrestricted license in good standing to practice pharmacy in the Commonwealth of Massachusetts and am currently engaged in pharmacy practice in the Commonwealth and qualify to provide collaborative drug therapy management services by virtue of having: (1) at least $1,000,000 (per occurrence) of professional liability insurance during the term of the agreement which specifically covers drug therapy; (2) earned a doctor of pharmacy degree or having completed five years of experience as a licensed pharmacist; (3) agreed to devote a portion of practice to the defined drug therapy area to be co-managed under this Agreement; (4) agreed to complete, in each year of the term of this two year Agreement, at least five additional contact hours or 0.5 continuing education units of Board of Registration in Pharmacy-approved continuing education that addresses the areas of practice generally related to the diseases and practices described in this Agreement; and (5) agreed to maintain a current controlled substance registration issued by the Massachusetts Department of Public Health during the term of the Agreement, pursuant to G.L. c. 94C, §§ 7 and 9 and 105 CMR 700.000.

Signed under pain and penalties of perjury this _____ day of (Month) _____, Year)_____

SIGNED:_____

Signature of Authorized Pharmacist

Part IV. Responsibilities and Agreements of the Parties to this Agreement

A. Responsibilities of the Authorized Pharmacist:

(1) I shall have signed, and obtained a copy of, a fully executed written CDTM agreement which complies with the requirements of the Board of Registration in Pharmacy (247 CMR 16.00) and the Board of Registration in Medicine (243 CMR 2.12) before rendering or advertising any CDTM services;
(2) I shall maintain contact with and document communication with the supervising physician with whom I have entered into this CDTM Agreement, as described in Part III above;
(3) I shall practice in accordance with Board of Registration in Pharmacy rules and regulations;
(4) I shall provide CDTM services only to patients who are 18 years of age or older for whom a written, signed current patient referral and consent has been provided by the supervising physician. The original patient referral or subsequent referral shall specify the primary diagnosis for the patient and any secondary diagnoses and include the patient's written informed consent to the collaboration;
(5) I shall maintain a written record of both the individual patient referral and the patient's written informed consent to the collaboration in the patient's record which the supervising physician and I will maintain in accordance with responsibilities and protocols noted above and required by 247 CMR 16.00.
(6) I shall obtain and maintain a current controlled substance registration issued by the Massachusetts Department of Public Health pursuant to G.L. c. 94C, §§ 7 and 9 and 105 CMR 700.00;
(7) I shall provide a copy of an initial prescription or a modification or discontinuation of a prescription to the supervising physician within 24 hours of issuance, unless more urgent notification is required under the circumstances and will note the action taken in the patient's medical record;
(8) I shall order and evaluate the results of laboratory tests directly related to drug therapy in accordance with approved protocols under the supervision of, or in direct consultation with the supervising physician.
(9) I shall maintain a current CDTM agreement in the patient's medical record at the primary practice setting, and will ensure that these documents are readily retrievable at the request of the Board of Registration in Pharmacy and Board of Registration in Medicine.

B. Responsibilities of the Supervising Physician:

(1) I shall have signed, and obtained a copy of, a fully executed written CDTM agreement which complies with the requirements of the Board of Registration in Medicine (243 CMR 2.12) and the Board of Registration in Pharmacy (247 CMR 16.00) and before rendering or advertising any CDTM services;
(2) I shall be responsible for obtaining the written consent of the patient to receive CDTM services from the authorized pharmacist; and shall execute a written CDTM referral for each patient which shall include, but not be limited to, the patient's name and address, the primary diagnosis for which CDTM services are

authorized, any known patient drug allergies, a statement that the patient has executed a written consent to CDTM services and any specific instructions for the patient;

(3) I shall maintain the original current patient consent to the CDTM referral in the patient's record maintained in my practice and shall transmit a copy of the patient's consent to the authorized pharmacist with 24 hours; and will provide copies of the referral and consent to the patient in a timely manner; and

(4) I shall maintain the original copy of the current CDTM Agreement, including the original patient referral and consent, in the patient's medical record, and will ensure that these documents are readily retrievable at the request of the Board of Registration in Pharmacy and Board of Registration in Medicine.

C. Agreements of the Parties

We, the undersigned authorized pharmacist and supervising physician, do hereby agree:

(1) The collaborative practice authorized pursuant to this Agreement is within the scope of our respective medical and pharmacy practices;

(2) We will immediately provide written notice to all parties to this agreement if either of us is disciplined by our respective professional licensing board, by agreement or Board order, or if either of us is otherwise subject to any practice restrictions;

(3) To review and renew this Agreement at least every two years;

(4) If the Agreement is terminated or not renewed, that prior to termination or non-renewal of this Agreement, we will arrange for an uninterrupted continuation of patient drug therapy and inform each patient in writing of the termination or non-renewal of the Agreement and of the procedures in place for the continuation of the patient's drug therapy; and

(5) The information provided in this CDTM Agreement is complete and accurate and that we will abide by the terms of the Agreement.

Signed by:

Authorized Pharmacist	MA License No.	Date

Supervising Physician	MA License No.	Date